ACTEMRA® Pediatrics (> 2 y.o.)
Infusion Form

Fax Referral To:
877-438-9380

Continuum Health

## PREVIOUS ADMINISTRATION

**Please provide the following information:** Last Infusion Date: __________________ Next Infusion Date: __________________

## Patient Information

Patient Name:_________________________ DOB: _______________ Sex: M F Height: ______ Weight: ____________________

Phone Number: ____________________________ Email Address: ____________________________________________

Allergies: ______________________________________________ Is the patient Diabetic: Y N ICD-10 Code: __________________

Emergency Contact:__________________________________________ Phone Number: ________________________________

Primary Diagnosis: _____ Juvenile Rheumatoid Arthritis with Systemic Onset
_____ Juvenile Rheumatoid Polyarthritis (seronegative)
Other:______________________________

**Clinical Information – Please fax with Infusion Order Form and other requested items below:**

- Clinical MD Notes, labs, test supporting primary diagnosis
  - TB Screening Results
  - Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody)
  - Recent Lab Results (including CBC with diff, LFTs, Platelets, & Lipid Panel)
- Previous Drug Therapy History, including therapies trailed/failed and date of last administration:
  Agent: ___________________________ Date:______________Desired Washout Period: ________ weeks

**Infusion Center – Lab Orders: (Check for Infusion Center to Manage):**

- ❏ CBC with diff, Platelets, and LFTs prior to second infusion and every _______ weeks.
- ❏ Lipid Panel prior to the second infusion and then every six months

**Please attach the following: 1. List of current Medications, 2. Copy of the patient's Insurance Card, 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs**

## Physician Information

Prescribing Physician: ______________________________ Practice Name: ______________________________
Practice Phone: ______________________________ Practice Fax: ______________________________
Email: ______________________________ Office Contact: ______________________________
Co-managing Physician: ______________________________ Phone/Email: ______________________________

## Medication Order

***Medication:*** **ACTEMRA® (tocilizumab)**

Administer Actemra IV over 1 hour. ***Select Dose Below***

**For Polyarticular JIA – Infuse every 4 weeks**

- ❏ **Less Than 30 kg weight: 10 mg/kg**
- ❏ **30 kg or above weight: 8 mg/kg**

**_______#Refills (Recommend 5)**

**For Systemic JIA – Infuse every 2 weeks**

- ❏ **Less Than 30 kg weight: 12 mg/kg**
- ❏ **30 kg or above weight: 8 mg/kg**

**_______#Refills (Recommend 10)**

**By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

______________________ Physician's NPI#

______________________ Physician's Address

______________________ Prescriber's Signature

______________________ Date

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